907 KAR 1:170E
Payments for Home and Community Based Waiver Services

Material Incorporated by Reference

MAP-1021, ADHC Payment Determination Form
(August 2000 Edition) - clean

Adult Day Health Care Physician Statement
(August 2000 Edition) - clean

The "Annual Medicaid Home Health/HCB Cost Report"
(May 1991 Edition) – clean

The "Annual Medicaid Home Health/HCB Cost Report Instructions"
(May 1991 Edition) - clean

The "Annual Medicaid Home Health/HCB Cost Report"
(October 1999 Edition) - dirty

The "Annual Medicaid Home Health/HCB Cost Report Instructions"
October 1999 Edition - dirty

Filed: _____

CLEAN

ADULT DAY HEALTH CARE CENTER
LEVEL II REIMBURSEMENT DETERMINATION FORM

An Adult Day Health Care (ADHC) provider may apply for Level II reimbursement if eighty (80) percent of those individuals receiving services on a "SNAP SHOT" day determined by DMS and based on an average daily census of at least twenty (20) individuals enrolled in the ADHC (limited to: Home and Community Based Waiver clients, private pay or covered by insurance and diagnosed as having:

> A disability that manifested itself before the age of twenty – two (22) that is attributable to mental retardation or cerebral palsy, epilepsy, autism or neurological conditions that results, in an impairment of general intellectual functioning or adaptive behavior. This neurological condition should significantly limit the individual in two (2) or more of the following skilled areas: communication, self-care, home-living, social skills, community use, self direction, health and safety, functional academics, leisure, work and limitation similar to that of a person with mental retardation, this limitation should result directly from or is significantly influenced by substantial cognitive deficits. The limitation may not be attributable to only a physical or sensory impairment or mental illness.

Provider Name _____ **Provider #** _____

Street Address _____ **Phone #** ___-_____-_____

City, State, Zip Code _____

"SNAP SHOT" DATE _____/_____/_____
(Month) (Day) (Year)

Average daily census shall be limited to those individuals designated as Home and Community Based Waiver, private pay or covered by insurance. (This definition does NOT include any individuals who are designated as or otherwise described by any of the following: NF/PASRR, SCL, ABI, EPSDT, or other Medicaid Waiver Program:

AVERAGE DAILY CENSUS _____

Please complete the following for each client in the ADHC that meets the criteria for Level II reimbursement.

NAME	MAID # IF APPLICABLE	DATE OF BIRTH	DIAGNOSIS	DATE OF ONSET

I VERIFY THE ABOVE INFORMATION IS ACCURATE.

_____ _____

(SIGNATURE) **(DATE)**

Mail original to:
Attention: HCB Waiver Supervisor
Healthcare Review Corporation
9200 Shelbyville Road, Suite 800
Louisville, KY 40222

Mail copy to:
Department for Medicaid Services
Division of Long Term Care
275 E. Main St., 6W-B
Frankfort, KY 40621

If additional space is needed, please attach as many addendum pages as necessary.

NAME	MAID # IF APPLICABLE	DATE OF BIRTH	DIAGNOSIS	APPX DATE OF ONSET

I verify the above information is accurate. (Initial)_____(Date) _____

ADULT DAY HEALTH CARE
ATTENDING PHYSICIAN STATEMENT

Re: Name of Individual _____
Address _____
City, State, Zip _____
Date of Birth _____
RE: Adult Day Health Care _____
Address _____
City, State, Zip _____
Provider # _____

An Adult Day Health Care (ADHC) provider may apply for Level II reimbursement if eighty (80) percent of those individuals receiving services on a "SNAP SHOT" day determined by DMS and based on an average daily census of at least twenty (20) individuals enrolled in the ADHC (limited to: Home and Community Based Waiver clients, private pay or insurance third party liability coverage) and diagnosed as having:

> A disability that manifested itself before the age of twenty – two (22) that is attributable to mental retardation or cerebral palsy, epilepsy, autism or neurological conditions that results, in an impairment of general intellectual functioning or adaptive behavior. This neurological condition should significantly limit the individual in two (2) or more of the following skilled areas: communication, self-care, home-living, social skills, community use, self direction, health and safety, functional academics, leisure, work and limitation similar to that of a person with mental retardation, this limitation should result directly from or is significantly influenced by substantial cognitive deficits. The limitation may not be attributable to only a physical or sensory impairment or mental illness.

The patient **meets** _____ **does not meet** _____ the requirements for **LEVEL II REIMBURSEMENT** according to the above diagnosis definition.

I verify the above statement is true.

Physician's Name (Please Print) _____

Physician's Signature _____ **Date** _____

ANNUAL COST REPORT

HOME HEALTH / HCB

FOR PERIOD BEGINNING _____

AND PERIOD ENDING _____

_____

NAME OF FACILITY

_____

VENDOR NUMBER

ADDRESS OF FACILITY

_____

_____

_____

_____

ANNUAL COST REPORT
HOME HEALTH & COMMUNITY BASED SERVICES
SCHEDULE A
STATISTICAL AND OTHER DATA

VENDOR NAME: _____ VENDOR NUMBER: _____

PERIOD COVERED BY STATEMENT: FROM: _____ TO: _____

TYPE OF CONTROL

1. VOLUNTARY NON-PROFIT:

CHURCH _____

OTHER-SPECIFY _____

_____

2. PROPRIETARY:

INDIVIDUAL _____

PARTNERSHIP _____

CORPORATION _____

3. GOVERNMENT:

STATE _____

COUNTY _____

CITY _____

HEALTH DEPT. _____

STATISTICS

		TOTAL UNIT/VISITS 1	XIX UNIT/VISITS 2
	HOME HEALTH		
1.	SKILLED NURSING		
2.	PHYSICAL THERAPY		
3.	SPEECH THERAPY		
4.	OCCUPATIONAL THERAPY		
5.	MEDICAL SOCIAL SERVICES		
6.	HOME HEALTH AIDE		
	HCB		
7.	CLIENT ASSESSMENT/REASSESSMENT		
8.	CASE MANAGEMENT		
9.	HOMEMAKER		
10.	PERSONAL CARE		
11.	RESPITE CARE		
12.	HOME ADAPTATION		
	HCB EXTENDED AREA		
13.	CLIENT ASSESSMENT/REASSESSMENT		
14.	CASE MANAGEMENT		
15.	HOMEMAKER		
16.	PERSONAL CARE		
17.	RESPITE CARE		
18.	HOME ADAPTATION		

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-1
ADJUSTMENTS TO EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

(1) DESCRIPTION	(2) A/B	(3) INC / <DEC>	(4) LINE #
1. TRADE, QUANTITY, TIME AND OTHER DISCOUNTS ON PURCHASES			
2. REBATES AND REFUNDS OF EXPENSES			
3. HOME OFFICE COSTS			
4. ADJUSTMENTS RESULTING FROM TRANSACTIONS WITH RELATED ORGANIZATIONS			
5. SALE OF MEDICAL RECORDS AND ABSTRACTS			
6. INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES.			
7. SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS			
8. SALE OF DRUGS TO OTHER THAN PATIENTS			
9. PHYSICAL THERAPY ADJUSTMENT			
10. INTEREST EXPENSE ON MEDICAID OVERPAYMENTS AND BORROWINGS TO REPAY MEDICAID OVERPAYMENTS			
11. OFFSET OF INVESTMENT INCOME			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
TOTAL (TO SCHEDULE B LINE 40, COLUMN 4.)			

COLUMN 2, (A) COST (B) REVENUE

HOME HEALTH AGENCY
SCHEDULE B-1a

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART I - GENERAL INFORMATION

1.	Total number of weeks worked (During which outside suppliers (excluding aides) worked)	
2.	Line 1 multiplied by 15 hours per week	
3.	Number of unduplicated HHA visits - Supervisors or therapists (See Instructions)	
4.	Number of unduplicated HHA visits - Therapy assistants (Include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit) (See Instructions)	
5.	Standard travel expense rate	
6.	Optional travel expense rate per mile	

		Supervisors 1	Therapists 2	Assistants 3	Aides 4
7.	Total hours worked				
8.	AHSEA (See Instructions)				
9.	Standard travel allowance (Cols 1 and 2, one-half of col 2, line 8; col 3, one-half of col 3, line 8)				xxxxxxxxxxx
10.	Number of travel hours (HHA only)				xxxxxxxxxxx
11.	Number of miles driven (HHA only)				xxxxxxxxxxx

PART II - SALARY EQUIVALENCY COMPUTATION

12.	Supervisors (Col 1, line 7 times col 1, line 8)	
13.	Therapists (Col 2, line 7 times col 2, line 8)	
14.	Assistants (Col 3, line 7 times col 3, line 8)	
15.	Subtotal Allowance Amount (Sum of lines 12-14)	
16.	Aides (Col 4, line 7 times col 4, line 8)	
17.	Total Allowance Amount (Sum of lines 15 and 16)	
	If the sum of cols 1-3, line 7, is greater than line 2, make no entries on lines 18 and 19 and enter on line 20 the amount from line 17. Otherwise, complete lines 18-20.	
18.	Weighted average rate excluding aides (Line 15 divided by the sum of cols 1-3, line 7)	
19.	Weighted allowance excluding aides (Line 2 times line 18)	
20.	Total Salary Equivalency (Line 17 or sum of lines 16 plus 19)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-1b

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART III – STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION – PROVIDER SITE
Standard Travel Allowance

21.	Therapists (Line 3 times column 2, line 9)	
22.	Assistants (Line 4 times column 3, line 9)	
23.	Subtotal (Sum of lines 21 and 22)	
24.	Standard Travel Expense (Line 5 times sum of lines 3 and 4)	
25.	Total Standard Travel Allowance and Standard Travel Expense at the Provider Site (Sum of lines 23 and 24)	

PART IV – STANDARD TRAVEL ALLOWANCE AND STANDARD TRAVEL EXPENSE COMPUTATION – HHA SERVICES OUTSIDE PROVIDER SITE
Standard Travel Expense

26.	Therapists (Line 3 times col 2, line 9)	
27.	Assistants (Line 4 times col 3, line 9)	
28.	Subtotal (Sum of lines 26 and 27)	
29.	Standard Travel Expense (Line 5 times sum of lines 3 and 4)	

Optional Travel Allowance and Optional Travel Expense

30.	Therapists (Sum of cols 1 and 2, line 10 times col 2, line 8)	
31.	Assistants (Col 3, line 10 times Col. 3, line 8)	
32.	Subtotal (Sum of lines 30 and 31)	
33.	Optional Travel Expense (Line 6 times sum of cols 1–3, line 11)	

Total Travel Allowance and Travel Expense – HHA Services; Complete one of the following three lines 34, 35 or 36, as appropriate.

34.	Standard Travel Allowance and Standard Travel Expense (Sum of lines 28 and 29 – See Instructions)	
35.	Optional Travel Allowance and Standard Travel Expense (Sum of lines 32 and 29 – See Instructions)	
36.	Optional Travel Allowance and Optional Travel Expense (Sum of lines 32 and 33 – See Instructions)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-1c

REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

VENDOR NAME:	VENDOR NO:	PERIOD ENDING:

PART V - OVERTIME COMPUTATION

	DESCRIPTION	THERAPISTS	ASSISTANTS	AIDES	TOTAL
		1	2	3	4
37.	Overtime hours worked during cost reporting period (If col 4, line 37, is zero or equal to or greater than 2,080, do not complete lines 38-45 and enter zero in each column of line 46)				
38.	Overtime rate (Multiply the amounts in cols 2-4, line 8 (AHSEA) times 1.5)				
39.	Total overtime (Including base and overtime allowance) (Multiply line 37 by line 38)				
	Calculation of Limit:				
40.	Percentage of overtime hours by category (Divide the hours in each column on line 37 by the total overtime worked - col. 4, line 37)				
41.	Allocation of provider's standard workyear for one full-time employee times the percentages on line 40 (See Instructions)				
	Determination of Overtime Allowance:				
42.	Adjusted hourly salary equivalency amount (AHSEA) (From Part I, cols 2-4, line 8)				
43.	Overtime cost limitation (Line 41 times line 42)				
44.	Maximum overtime cost (Enter the lesser of line 39 or line 43)				
45.	Portion of overtime already included in hourly computation at the AHSEA (Multiply line 37 by line 42)				
46.	Overtime allowance (Line 44 minus line 45 - if negative enter zero) (Col 4, sum of cols 1-3)				

PART VI - COMPUTATION OF PHYSICAL THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

47.	Salary equivalency amount (from Part II, line 20)	
48.	Travel allowance and expense - provider site (from Part III, line 25)	
49.	Travel allowance and expense - HHA services (from Part IV, lines 34, 35 or 36)	
50.	Overtime allowance (from Part V, col. 4, line 46)	
51.	Equipment cost (See Instructions)	
52.	Supplies (See Instructions)	
53.	Total Allowance (Sum of lines 47-52)	
54.	Total cost of outside supplier services (from provider records)	
55.	Excess over limitation (line 54 minus line 53 - transfer amount to line 9, SCH. B-1, If negative, enter zero)	

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE B-2

RECLASSIFICATION TO EXPENSE

VENDOR NAME: _____ VENDOR NUMBER: _____

PERIOD ENDING: _____

(1) DESCRIPTION	(2) LINE #	(3) INCREASE	(4) <DECREASE>
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			
21.			
22.			
23.			
24.			
25.			
26.			
27.			
28.			
29.			
30.			
31.			
32.			
33.			
34. TOTAL			

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE C

COST ALLOCATION STATISTICS

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

	(1) SQUARE FOOTAGE	(2) MILEAGE	(3) SALARIES	(4) ACCUMULATED COSTS
DIRECT SERVICES – HOME HEALTH				
17. MEDICAL SUPPLIES				
18. SKILLED NURSING				
19. PHYSICAL THERAPY				
20. SPEECH THERAPY				
21. OCCUPATIONAL THERAPY				
22. MEDICAL SOCIAL SERVICE				
23. HOME HEALTH AIDE				
DIRECT SERVICES – HCB				
24. CLIENT ASSESSMENT/REASSESSMENT				
25. CASE MANAGEMENT				
26. HOMEMAKER				
27. PERSONAL CARE				
28. RESPITE CARE				
29. HOME ADAPTATION				
DIRECT SERVICES – HCB EXTENDED AREA				
30. CLIENT ASSESSMENT/REASSESSMENT				
31. CASE MANAGEMENT				
32. HOMEMAKER				
33. PERSONAL CARE				
34. RESPITE CARE				
35. HOME ADAPTATION				
NON-REIMBURSABLE				
36. WAIVER #1 (24HR)				
37. WAIVER #2 (16HR)				
38. _____				
39. _____				
40. TOTAL				
41. TOTAL TO ALLOCATE				
42. UNIT COST MULTIPLIER				

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE C-1

COST ALLOCATION

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

	DIRECT EXPENSE 1	DEPR. BLDG. & EQUIP. PROPERTY TAXES, INS. PLANT & EQUIPMENT 2	VEHICLE DEPR. TRANS. VEHICLE INS. 3	EMPLOYEE HEALTH & WELFARE 4	SUB TOTAL 5	ALL OTHER GENERAL SERVICES COSTS 6	TOTAL COSTS 7
DIRECT SERVICES - HHA							
MEDICAL SUPPLIES							
SKILLED NURSING							
PHYSICAL THERAPY							
SPEECH THERAPY							
OCCUPATIONAL THERAPY							
MEDICAL SOCIAL SERVICES							
HOME HEALTH AIDES							
DIRECT SERVICES - HCB							
CLIENT ASSESSMENT/REASSESSMENT							
CASE MANAGEMENT							
HOMEMAKER							
PERSONAL CARE							
RESPITE CARE							
HOME ADAPTATION							
DIRECT SERVICES - HCB EXTENDED AREA							
CLIENT ASSESSMENT/REASSESSMENT							
CASE MANAGEMENT							
HOMEMAKER							
PERSONAL CARE							
RESPITE CARE							
HOME ADAPTATION							
NON-REIMBURSABLE							
WAIVER #1 (24HR)							
WAIVER #2 (16HR)							
_____							
_____							
TOTALS							

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE D
APPORTIONMENT OF PATIENT SERVICE COSTS

VENDOR NAME: _____ VENDOR NUMBER: _____ PERIOD ENDING: _____

PART I:

PATIENT SERVICES	VISITS BEFORE 07-01-- AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/ VISITS	AVERAGE COST PER UNIT/VISITS	XVIII COST LIMITS	XIX COSTS LIMITS	XIX PROGRAM UNIT/VISITS	COST OF SERVICES AVERAGE	XVIII	XIX
1	2	3	4	5	6	7	8	9	10	11
1. SKILLED NURSING						XXXXXXX				
2. PHYSICAL THERAPY						XXXXXXX				
3. SPEECH THERAPY						XXXXXXX				
4. OCCUPATIONAL THERAPY						XXXXXXX				
5. MEDICAL SOCIAL SERVICES						XXXXXXX				
6. HOME HEALTH AID SERVICES						XXXXXXX				
7. TOTAL (SUM OF LINES 1-6)			XXXXXXX	XXXXX	XXXXXXXXXXXXX	XXXXXXX				
8. TOTAL COST (LESSER OF COL. 9, 10, 11)										

PART II:

PATIENT SERVICES	VISITS AFTER 07-01-- AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/ VISITS	AVERAGE COST PER UNIT/VISITS	XVIII COST LIMITS	XIX COSTS LIMITS	XIX PROGRAM UNIT/VISITS	COST OF SERVICES AVERAGE	XVIII	XIX
1	2	3	4	5	6	7	8	9	10	11
1. SKILLED NURSING						XXXXXXX				
2. PHYSICAL THERAPY						XXXXXXX				
3. SPEECH THERAPY						XXXXXXX				
4. OCCUPATIONAL THERAPY						XXXXXXX				
5. MEDICAL SOCIAL SERVICES						XXXXXXX				
6. HOME HEALTH AID SERVICES						XXXXXXX				
7. TOTAL (SUM OF LINES 1-6)			XXXXXXX	XXXXX	XXXXXXXXXXXXX	XXXXXXX				
8. TOTAL COST (LESSER OF COL. 9, 10, 11)										
9. TOTAL XIX VISITS (LINE 7, COL 8, PART I + LINE 7, COL 8, PART II)							XXXXXXXX			

PART III:

MEDICAL SUPPLIES COMPUTATION

	TOTAL COST	TOTAL CHARGE	RATIO	XIX CHARGE	XIX COST
	1	2	3	4	5
1. MEDICAL SUPPLIES					
2. TOTAL COST OF SERVICES (LINE 8, COL 11, PART I + LINE 8, COL 11, PART II + LINE 1, COL. 5, PART III)					

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE D-1

CALCULATION OF REIMBURSEMENT SETTLEMENT

VENDOR NAME: _____ VENDOR # _____

PERIOD ENDING: _____

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

1. COST OF SERVICES (FROM SCHEDULE D, PART III, LINE 2) _____
2. TOTAL CHARGES FOR TITLE XIX SERVICES (FROM PCL'S) _____
3. EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (COMPLETE ONLY IF LINE 1 EXCEEDS LINE 2) _____

PART II COMPUTATION OF REIMBURSEMENT SETTLEMENT

4. TOTAL REASONABLE COST (FROM LINE 1) _____
5. EXCESS REASONABLE COST (FROM LINE 3) _____
6. SUBTOTAL (LINE 4 MINUS LINE 5) _____
7. AMOUNTS REC'D. FROM TPL / OTHER SOURCES (PCL'S) _____
8. AMOUNTS REC'D. FROM THE MEDICAID PROGRAM (PCL'S) _____
9. AMOUNT RECEIVED AS INCENTIVE PAYMENTS (PCL'S) _____
10. TOTAL INTERIM PAYMENTS (LINE 7 plus 8 minus 9) _____
11. BALANCE DUE PROVIDER / MEDICAID PROGRAM (LN. 6 minus 10) (INDICATE OVERPAYMENTS IN PARENTHESES) _____

ANNUAL COST REPORT
HOME AND COMMUNITY BASED
SCHEDULE E
APPORTIONMENT OF PATIENT SERVICE COSTS

VENDOR NAME:_____ VENDOR NUMBER:_____ PERIOD ENDING:_____

PART I

VISITS BEFORE 07-01-____

PATIENT SERVICE	AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISIT	XIX COST LIMITS	XIX UNIT/VISITS	COST OF SERVICES AVERAGE	COST OF SERVICES XIX
1	2	3	4	5	6	7	8
1. CLIENT ASSESSMENT/REASSESSMENT							
2. CASE MANAGEMENT							
3. HOMEMAKER							
4. PERSONAL CARE							
5. RESPITE CARE							
6. ADAPTATION PROGRAM							
7. TOTAL (SUM OF LINE 1-6)			XXXXXXXXXX	XXXXXX			

PART II

VISITS AFTER 07-01-____

PATIENT SERVICE	AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISIT	XIX COST LIMITS	XIX UNIT/VISITS	COST OF SERVICES AVERAGE	COST OF SERVICES XIX
1	2	3	4	5	6	7	8
8. CLIENT ASSESSMENT/REASSESSMENT							
9. CASE MANAGEMENT							
10. HOMEMAKER							
11. PERSONAL CARE							
12. RESPITE CARE							
13. ADAPTATION PROGRAM							
14. TOTAL (SUM OF LINE 8-13)			XXXXXXXXXX	XXXXXX			

PART III

CALCULATION OF REIMBURSEMENT SETTLEMENT

15. ALLOWABLE COST OF PATIENT SERVICES (LESSER OF LINE 7, COL. 7 OR LINE 7, COL. 8.)	
16. ALLOWABLE COST OF PATIENT SERVICES (LESSER OF LINE 14, COL. 7 OR LINE 14 COL 8.)	
17. TOTAL ALLOWABLE COST OF PATIENT SERVICES, (LINE 15 + LINE 16, LESS AMOUNTS FROM SCHEDULE E-1, AND E-2)	
18. TOTAL CHARGES FOR WAIVER PROGRAM SERVICES FROM PCL'S.	
19. REIMBURSABLE COST (LESSER OF LINE 17 OR LINE 18).	
20a. AMOUNT RECEIVED FROM PROGRAM FOR WAIVER PROGRAM SERVICES.	
20b. CONTINUING INCOME OR TPL.	
21. TOTAL RECEIVED (LINE 20a + 20b)	
22. BALANCE DUE (PROGRAM)/VENDOR (LINE 19 minus 21)	

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER
SCHEDULE E-1
RESPITE CARE COST LIMITATION

VENDOR NAME: ______________________________

VENDOR NO.: __________ PERIOD ENDING: __________

KMAP RECIPIENT 1	(A) RESPITE UNITS 2	AVG. COST 3	TOTAL COST 4	COST IN EXCESS OF LIMITATION (B) 5
TOTAL NON-ALLOWABLE COST (TO SCHEDULE E, LINE 17)				

(A) UNITS FOR FISCAL YEAR (COLUMN 2)

(B) COST IN EXCESS OF $2,000.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER
SCHEDULE E-2

STATEMENT TO HOME ADAPTATION EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

1. TOTAL ADAPTATION EXPENSE (FROM SCHEDULE E, LINE 6, COL 2) _____
2. DIRECT ADAPTATION EXPENSE (FROM SCHEDULE B, LINE 29, COL.6) _____
3. OVERHEAD FACTOR (DIVIDE LINE 1 by LINE 2) _____

KMAP RECIPIENT 1	DIRECT COST 2	ADJUSTED COST (A) 3	COST IN EXCESS OF LIMITATION (B) 4
—			
4. TOTAL NON-ALLOWABLE KMAP COST (TRANSFER TO SCH. E, LINE 17)			

(A) DIRECT COST X OVERHEAD FACTOR (LINE 3)

(B) COST IN EXCESS OF $500.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME AND COMMUNITY BASED (EXTENDED AREA)
SCHEDULE F

APPORTIONMENT OF PATIENT SERVICE COSTS

VENDOR NAME:_____ VENDOR NUMBER:_____ PERIOD ENDING:_____

PATIENT SERVICE	AMOUNTS (Sch C-1 Col 7)	TOTAL UNIT/VISITS	AVERAGE COST PER UNIT/VISITS	XIX UNIT/VISITS	XIX COST
1	2	3	4	5	6
1. CLIENT ASSESSMENT/REASSESSMENT					
2. CASE MANAGEMENT					
3. HOMEMAKER					
4. PERSONAL CARE					
5. RESPITE CARE					
6. HOME ADAPTATION PROGRAM					
7. TOTAL (SUM OF LINE 1-6)					
8. ALLOWABLE COST OF PATIENT SERVICES (LINE 7, COL. 6)			XXXXXXXXXXX		
9. TOTAL OF ALLOWABLE COST OF PATIENT SERVICES, (LINE 8, LESS AMOUNTS FROM SCHEDULE F-1, AND F-2)					
10. TOTAL CHARGES FOR WAIVER PROGRAM SERVICES FROM PCL'S.					
11. REIMBURSABLE COST (LESSER OF LINE 9 OR LINE 10).					
12a. AMOUNT RECEIVED FROM PROGRAM FOR WAIVER PROGRAM SERVICES.					
12b. CONTINUING INCOME OR TPL.					
13. TOTAL RECEIVED (LINE 12a + 12b)					
14. BALANCE DUE (PROGRAM)/VENDOR (LINE 11 minus LINE 13)					

Transmittal #9
5/1/91

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER (EXTENDED AREA)
SCHEDULE F-1
RESPITE CARE COST LIMITATION

VENDOR NAME: ______________________________

VENDOR NO: ____________ PERIOD ENDING: ____________

KMAP RECIPIENT 1	(A) RESPITE UNITS 2	AVG. COST 3	TOTAL COST 4	COST IN EXCESS OF LIMITATION (B) 5
TOTAL NON-ALLOWABLE COST (TO SCHEDULE F, LINE 9)				

(A) UNITS FOR FISCAL YEAR (COLUMN 2)

(B) COST IN EXCESS OF $2,000.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME & COMMUNITY BASED WAIVER (EXTENDED AREA)
SCHEDULE F-2

STATEMENT TO HOME ADAPTATION EXPENSE

VENDOR NAME: _____

VENDOR NUMBER: _____

PERIOD ENDING: _____

1. TOTAL ADAPTATION EXPENSE (FROM SCHEDULE E, LINE 6, COL 2) _____
2. DIRECT ADAPTATION EXPENSE (FROM SCHEDULE B, LINE 35, COL.6) _____
3. OVERHEAD FACTOR (DIVIDE LINE 1 by LINE 2) _____

KMAP RECIPIENT 1	DIRECT COST 2	ADJUSTED COST (A) 3	COST IN EXCESS OF LIMITATION (B) 4
4. TOTAL NON-ALLOWABLE KMAP COST (TRANSFER TO SCH. F, LINE 9)			

(A) DIRECT COST X OVERHEAD FACTOR (LINE 3)

(B) COST IN EXCESS OF $500.00 PER MEDICAID RECIPIENT PER FISCAL YEAR

ANNUAL COST REPORT
HOME HEALTH AGENCY
SCHEDULE G
HOME HEALTH AGENCY DATA

VENDOR NAME: _____
VENDOR NUMBER: _____
PERIOD ENDING: _____

All vendors are to complete A, B, C and D

A. STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS

1. In the amount at cost to be reimbursed by the Program, are any costs included which are the result of transactions with any related organizations?

_____ YES _____ NO

2. Enter related party transactions below, if additional space is required attach additional sheet(s).

SCHEDULE	LINE NO.	ITEM	AMOUNT

3. Name and percent of direct or indirect ownership of the related organization.

NAME OF OWNER	NAME OF RELATED ORGANIZATION	PERCENT

B. STATEMENT OF COMPENSATION OF OWNERS

			PARTNERS	CORPORATION OFFICERS	
NAME	TITLE AND FUNCTION	PERCENT OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT OF OPERATING PROFIT OR LOSS	PERCENT OF VENDOR'S STOCK OWNED	TOTAL COMPEN-SATION

C. STATEMENT OF COMPENSATION PAID TO ADMINISTRATORS AND / OR ASSISTANT ADMINISTRATORS (OTHER THAN OWNERS)

NAME	TITLE AND FUNCTION	PERCENT OF CUSTOMARY WORK WEEK DEVOTED TO BUSINESS	PERCENT OF PERIOD EMPLOYED	TOTAL COMPENSATION FOR THE PERIOD

D. CERTIFICATION BY OFFICER OR DIRECTOR OF THE AGENCY

INTENTIONAL MISREPRESENTATIONS OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND / OR IMPRISONMENT UNDER FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Home Health Agency Cost Report(s) for the cost reporting period beginning _____, prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

Signature of Officer or Director Title Date

113. INTRODUCTION

These instructions are intended to guide vendors in preparing the annual cost report. These forms shall be used by all participating home health agencies for cost reporting periods beginning on or after June 1, 1990. Some schedules are not required for all vendors and these need not be completed. However, the entire cost report shall be submitted to the Department. Schedules which do not apply shall be marked accordingly, and a brief explanation as to why these are not needed shall be annotated on the appropriate schedules.

In completing the schedules the period beginning and period ending, the vendor name, identification number and address shall be indicated on the cover page. In addition, the vendor name, the vendor identification number and the inclusive dates covered by this cost report shall be indicated on each page. Facilities shall submit a cost report prepared on the accrual basis of accounting and otherwise consistent with generally accepted accounting principles.

Also, in completing the schedules, reductions to expenses shall always be shown in brackets.

SCHEDULE A - HOME HEALTH AND COMMUNITY-BASED SERVICES

STATISTICAL AND OTHER DATA

A. General -

Item 1 - Home Health Agency Information -- Enter the requested information in the space provided. Include the name of the agency and the vendor number. Enter the beginning and ending dates of the period covered by this cost report.

Item 2 - Agency Identifier -- Check the appropriate line for items 1 through 3.

1. Voluntary Non-Profit -- Indicate by checking appropriate line -- Church or Other.

2. Proprietary Organization -- Check if the Home Health Agency (HHA) is owned and operated by an individual or a business corporation. The organization may be a sole proprietorship, partnership (including limited partnership and joint stock company) or corporation.

3. Official (Governmental Agency) -- Check if the HHA is administered by a state, county, city, or health department. Indicate the type of official agency by checking the appropriate line.

B. Statistics --

Columns 1 and 2. Enter in Column 1, the number of the total agency visits/units for each discipline lines 1 through 18. Enter in Column 2, the number of Title XIX visits/units for each discipline lines 1 through 18.

SCHEDULE B - OPERATING EXPENSES

This Schedule provides for recording of direct costs such as salaries, fringe benefits, transportation and contracted services, as well as other costs to arrive to identifiable agency costs in Column 6. Also, it provides for the reclassification and adjustments to certain accounts. The total direct expenses before grouping, reclassifications and adjustments are obtained from the vendor's records.

The costs to be entered in Columns 1 and 2 are only those actual costs incurred by or for the HHA for which the cost report is prepared. If the reporting entity is a certified "sub unit" of a State Health Department, the amounts to be entered are only those amounts that are directly applicable to the "sub unit." The aggregation and reallocation of costs at the State level shall not be acceptable.

Schedule B shall be completed by all facilities.

Columns 1 and 2: The expenses listed in these columns shall agree with the provider's records. Hospital-based facilities should transfer the direct cost for salaries and other off their Medicare Supplemental Worksheet H and include in Columns 1 and 2 on Schedule B.

Salary expenses shall be reported in Column 1. The costs of purchased services, supplies and all other costs are entered in Column 2.

Column 3: Enter the sum of Columns 1 and 2.

Column 4: This column is for adjustments to allowable costs as may be necessary in accordance with general policies and principles. Enter on appropriate lines as indicated on Schedule B-1.

Column 5: This column is utilized to reclassify expenses. Reclassification shall be detailed on Schedule B-2.

Column 6: Enter the sum of Columns 3, 4, and 5.

SCHEDULE B-1 - ADJUSTMENTS TO EXPENSE

This schedule provides for the adjustments to the expense listed on Schedule B, Column 3. These adjustments are to be made on the basis of "cost" or "amount received" as indicated by the symbols entered in Column 2 "A" for cost or "B" for amount received. Line descriptions indicate the more common activities which affect allowable cost, or result in costs incurred for reasons other than patient care and, thus, require adjustments.

If an adjustment to an expense affects more than one (1) cost center, the adjustments to expense shall reflect the adjustment to each cost center on a separate line on Schedule B-1.

Types of items to be entered on Schedule B-1 are:
(1) those needed to adjust expenses to reflect actual expenses incurred; (2) those items which constitute recovery of expenses through sales, charges, fees, grants, gifts, etc.; (3) those items needed to adjust expenses in accordance with Medicaid principles of reimbursement; and (4) those items which are provided for separately in the cost apportionment process. Hospital-based facilities shall adjust their cost on this schedule to agree with cost on Medicare Worksheet H-4, Column 6.

Column 1, Line Descriptions:

Line 1 - Trade, Quantity, Time and Other Discounts on Purchases

Line 2 - Rebates and Refunds of Expenses

Line 3 - Home Office Costs - Enter on this line allowable home office costs which have been allocated to the provider.

Line 4 - Adjustments Resulting from Transactions with Related Organizations - The amount to be entered on this line is obtained from schedule G Part A, Subpart 2.

Line 5 - Sale of Medical Records and Abstracts - Enter the amount received from the sale of medical records and abstracts and offset the amount against the A & G cost centers.

Line 6 - Income from Imposition of Interest, Finance or Penalty Charges - Enter on this line the cash received from imposition of interest, finance or penalty charges on overdue receivables. This income shall be used to offset the allowable A & G costs.

Line 7 - Sale of Medical and Surgical Supplies to Other than Patients

Line 8 - Sale of Drugs to Other than Patients

Line 9 - Physical Therapy Adjustment - Where an HHA purchases physical therapy services furnished by an outside supplier. Schedules B-1a, B-1b, and B-1c shall be completed to compute the reasonable cost determination. Enter on this line any adjustment (Excess cost over Limitations) from Schedule B-1c, Part V, line 49.

Line 10 - Interest Expense on Borrowing to Repay Medicaid Overpayments

Line 11 - Offset of Investment Income

Line 12-28 - Enter on these lines any additional adjustments which are required which affect proper cost allocation of expenses. The lines shall be appropriately labeled to indicate the nature of the required adjustments.

Column 2: On each line enter an "A" if the amount in Column 3 is actual cost or a "B" if the amount in Column 3 is the revenue received for the item in Column 1.

Column 3: On each line indicate the amount to be adjusted.

Column 4: Indicate the line number on Schedule B that is to be adjusted.

SCHEDULE B-1a - REASONABLE COST DETERMINATION FOR PHYSICAL THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

This schedule provides for the computation of any needed adjustments to costs applicable to physical therapy services furnished by outside suppliers. The information required on this worksheet shall provide for, in the aggregate, all data for physical therapy services furnished by all outside suppliers in determining the reasonableness of physical therapy costs.

If a provider contracts with an outside supplier for physical therapy services, the potential for limitation and the amount of payment a provider can receive depends on several factors:

1. an initial test to determine where these services are categorized as intermittent part-time or full-time services;

2. the location where the services are rendered, i.e., provider site or HHA home visit;

3. for HHA services, whether detailed time and mileage records are maintained by the contractor and HHA;

4. add-ons for supervisory functions, aides, overtime, equipment and supplies;

5. determinations of reasonableness of rates charged by the supplier compared with the going rates in the area.

Part I - General Information - This part provides for furnishing certain information concerning physical therapy services furnished by outside suppliers.

Line 1 - Enter on this line the number of weeks that services were performed at the provider site, count only those weeks during which a supervisor, therapist or an assistant was on site. For services performed at the patient's residence, count only those weeks during which services were rendered by supervisors, therapists, or assistants to patients of the home health agency. Weeks where services were performed both at the provider's site and at the patient's home are only counted once.

Line 2 - Multiply the amount on line 1 by 15 hours per week. This calculation is used to determine whether services are full-time or intermittent part-time.

Line 3 - Enter the number of unduplicated HHA visits made by the supervisor or therapist. Only count one (1) visit when both the supervisor and therapist were present during the same visit.

Line 4 - Enter the number of unduplicated HHA visits made by the therapy assistant. Do not include in the count on this line the visits where either the supervisor or therapist were present during the same visit.

Line 5 - Enter on this line the Standard Travel Expense Rate applicable as published in HCFA Pub. 15-I, Chapter 14.

Line 6 - Enter on this line the Optional Travel Expense Rate applicable as published in HCFA Pub. 15-I, Chapter 14. This rate may only be used for home health patient services for which time records are available.

Line 7 - Enter on this line and in the appropriate columns the total number of hours worked for physical therapy supervisors, therapists, therapy assistants, and aides furnished by outside suppliers.

Line 8 - Enter in each column on this line the appropriate adjusted hourly salary equivalency amount (AHSEA). These amounts are the prevailing hourly salary rate plus the fringe benefit and expense factor described in HCFA Pub. 15-I, Chapter 14. These amounts are determined on a periodic basis for appropriate geographical areas, and are published as exhibits at the end of Chapter 14. Use the appropriate exhibit for the period of this cost report.

Enter in column 1 the supervisor's AHSEA, adjusted for administrative and supervisory responsibilities, which are determined in accordance with the provisions of HCFA Pub. 15-I, Subsection 1412.5. Enter in columns 2, 3, and 4 (for therapists, assistants and aides respectively) the AHSEA from the appropriate exhibit found in HCFA Pub. 15-I, at the end of Chapter 14 or the latest publication of rates. Where assistants' going hourly rate in the area is unobtainable, no more than 75 percent of the therapist AHSEA shall be used. The cost of services of a therapy aide or trainee shall be evaluated at the hourly rate not to exceed the hourly rate paid to the provider's employees of comparable classification or qualification, e.g., nurses' aides.

Line 9 - Enter on this line the standard travel allowance equal to one-half of the AHSEA as follows: enter in columns 1 and 2, one-half of the amount in column 2, line 8, and enter in column 3, one-half of the amount in column 3, line 8.

Lines 10 and 11 - Enter on these lines, for HHA services only, the number of travel hours and number of miles driven, respectively, where time records of visits are kept.

NOTE: No travel allowance for aides employed by outside suppliers shall be allowed.

Part II - Salary Equivalency Computation - This part provides for the computation of the full-time or intermittent part-time salary equivalency.

Where the provider furnishes physical therapy services by outside suppliers for health care program patients, but simply arranges for the services for nonhealth care program patients and does not pay the nonhealth care program portion of the services, its books shall reflect only the cost of the health care program portion. Where

the provider can "gross up" its costs and charges in accordance with provisions of HCFA Pub. 15-I, Subsection 2314, the facility shall complete Part II, lines 12 through 17 and 20 in all cases, and lines 18 and 19 where appropriate.

Line 12-17 - These lines shall be completed for the purpose of computing the total salary equivalency allowance amounts by multiplying the total hours worked (line 7) times the adjusted hourly salary equivalency amount for supervisors, therapists, assistants and aides.

Lines 18 and 19 - These lines shall be completed if the sum of hours in columns 1-3, line 7, is less than or equal to the product found on line 2. (See exception above where the provider shall not "gross up" its costs and charges and services are provided to program patients only.)

Line 20 - Where there are no entries on lines 18 and 19, enter the amount on line 17, otherwise enter the sum of the amounts on line 16 plus line 19.

SCHEDULE B-1b - Part III - Travel Allowance and Travel Expense Computation - Provider Site. This part provides for the computation of the standard travel allowance and standard travel expense for services rendered on site.

Lines 23-27 - These lines provide for the computation of the standard travel allowance and standard travel expense for physical therapy services performed at your site. One (1) standard travel allowance is recognized for each day an outside supplier performs skilled physical therapy services at your site. For example, if a contracting organization sends three (3) therapists to you each day, only one (1) travel allowance is recognized per day.

Line 23 - Include the standard travel allowance for supervisors and therapists. This standard travel allowance for supervisors appropriately does not take into account the additional allowance for administrative and supervisory responsibilities.

Part IV - Travel Allowance and Travel Expense Computation - HHA Services Outside Provider Site. - This part provides for the computation of both the standard travel allowance and standard travel expense and the optional travel allowance and the optional travel expense.

Lines 26-29 - These lines provide for the computation of the standard travel allowance and standard travel expense for physical therapy services performed in conjunction with home health agency visits. These lines shall be used only if the provider does not use the optional method of computing travel. A standard travel allowance shall be recognized for each visit to a patient's residence. If services are furnished to more than one (1) patient at the same location, only one (1) standard travel allowance shall be permitted, regardless of the number of patients treated.

Lines 30-33 - These lines provide for the optional travel allowance and optional travel expense computations for physical therapy services in conjunction with home health services. The optional travel allowance is computed on lines 30 through 32. The optional travel expense is computed on line 33.

Lines 34-36 - Only one (1) of the options on lines 34-36 shall be chosen and completed. However, lines 35 or 36 may be used where the provider maintains time records of visits.

SCHEDULE B-1c - Part V - Overtime Computation - This part provides for the computation of an overtime allowance if an individual employee of the outside supplier performs services for the provider in excess of the provider's standard work week. No overtime allowance shall be given to a therapist who receives an additional allowance for supervisory or administrative duties.

Line 37 - Enter in the appropriate columns the total overtime hours worked. If the total hours in column 4 are either zero or equal to or greater than 2080 the overtime computation shall not be applicable, no further entries on lines 38-45 shall be made, and zero shall be entered in each column of line 46. The sum of the hours recorded in columns 1 through 3 shall be entered in column 4.

Line 38 - Enter in the appropriate column the overtime rate which is the AHSEA from line 8, column as appropriate, times 1.5.

Line 40 - Enter the percentage of overtime hours, by class of employee, which is determined by dividing each column on line 37 by the total overtime hours in column 4, line 37.

Line 41 - This line is for the allocation of a provider's standard workyear for one (1) full-time employee. Enter the number of hours in the standard workyear for one (1) full-time employee in column 4 of this line. Multiply the standard workyear in column 4 by the percentage on line 40 and enter the results in the corresponding columns of this line.

Line 42 - Enter in columns 1 through 3 the AHSEA from Part I, line 8, columns 2 through 4, as appropriate.

Part VI - Computation of Physical Therapy Limitation and Excess Cost Adjustment - This part provides for the calculation of the adjustment to physical therapy service costs in determining the reasonableness of physical therapy cost.

Lines 51 and 52 - If the outside supplier provides the equipment and supplies used in furnishing direct services to the provider's patients, the actual cost of the equipment and supplies incurred by the outside supplier, as specified in HCFA Pub. 15-I, Subsection 1412.1, may be considered as an additional allowance in computing the limitation.

Line 54 - Enter the amounts paid or payable to the outside suppliers for physical therapy services rendered during the period as reported in the cost report. This includes any payments for supplies, equipment use, overtime or any other expense related to supplying physical therapy services for the provider.

Line 55 - Enter on this line the excess cost over the limitation, i.e., line 54 minus line 53. If negative, enter zero. Transfer the amount on this line to Schedule B-1, line 9.

SCHEDULE B-2 - RECLASSIFICATIONS TO EXPENSE

This schedule provides for the reclassification of expense accounts to effect proper cost allocation under cost finding. The following are some examples of costs which shall be reclassified.

A. Licenses and Taxes (Other Than Income Taxes) - This expense consists of the business license expense and tax expense incidental to the operation of the agency. These expenses shall be included in the Administrative and General (A & G) cost centers, Schedule B, line 8.

B. Interest - Short-term interest expense relates to borrowings for agency operations. The full amount of this cost shall be reclassified to A & G, Schedule B, line 8.

C. Insurance - Malpractice, Insurance - Other - Reclassify these insurance expenses to A & G, Schedule B, line 8. Malpractice insurance may be reclassified directly to the applicable cost centers (other than A & G) only if the insurance policy specifically and separately identifies the premium for each cost center involved.

D. If a provider purchases services (e.g., physical therapy) under arrangements for Medicaid patients, but does not purchase the services under arrangements for non-Medicaid patients, the providers' books shall reflect only the cost of the Medicaid services. However, if the provider does not use the "grossing up" technique for purposes of allocating overhead, and if the provider incurs related direct costs applicable to all patients, Medicaid and non-Medicaid (e.g., paramedics or aides who assist a physical therapist in performing physical therapy services), the related costs shall be reclassified from the HHA Reimbursable Service cost center and allocated as part of administrative and general expense.

E. Leases - This expense consists of all rental costs of buildings and equipment incidental to the operation of the HHA. Any lease which cannot be identified to a special cost center and is incidental to the general overall operation of the agency shall be included in the A & G account, Schedule B, line 8.

Column 1: Indicate the description of item to be reclassified on lines 1 through 33.

Column 2: Indicate line number from Schedule B where reclassification is entered.

Columns 3 and 4: Enter the amounts of the increase or decrease. The totals on line 34 column 3 and column 4 should be equal.

SCHEDULES C, C-1 - COST ALLOCATION STATISTICS AND COST ALLOCATIONS

Schedules C and C-1 provide for simplified cost finding. The simplified cost finding methodology provides for allocating general service (overhead) costs directly to revenue producing and non-reimbursable cost centers.

Schedule C: This schedule is used to provide the statistics necessary for the allocation of general services costs among the service areas on Schedule C-1.

Column 1: Enter in Column 1, the total square feet of the building and fixtures applicable to the cost center to which depreciation shall be allocated on Lines 17 through 39.

Line 40 is the total of lines 17 through 39.

Line 41 is the total of Lines 1, 3, 4, 10, 11, and 14, Column 6, Schedule B.

Line 42, divide line 41 by line 40 and enter the amount on line 42.

Column 2: Enter in column 2, the mileage for each service area on Lines 17 through 39.

Line 40 is the total of lines 17 through 39.

Line 41 is the total of lines 2, 5 and 13, Column 6, Schedule B.

Line 42, divide line 41 by line 40 and enter the amount on line 42.

Column 3: Enter in Column 3 the gross salaries paid to employees in each service area on Lines 18 through 39.

Line 40 is the total of lines 17 through 39.

Line 41 is the total of line 7, Column 6, Schedule B.

Line 42, divide line 41 by line 40 and enter the amount on line 42.

Column 4: Enter in Column 4, accumulated costs on lines 17 through 39, Column 5, Schedule C-1.

Line 40 is the total of lines 17 through 39, Column 4.

Line 41 is the total of lines 6, 8, 9, 12, 15 and 16, Schedule B.

Line 42, divide line 41 by line 40; enter the resulting unit cost multiplier on line 42 (Example: round to four decimal places .6224).

SCHEDULE C-1: COST ALLOCATION

Column 1: Enter the direct costs associated with the services listed on lines 17 through 39, Column 6, Schedule B.

Columns 2, 3, and 4: Multiply the unit cost multiplier on Schedule C by the detail on Schedule C. The products shall be entered on the corresponding lines on C-1.

Column 5: The sum of Columns 1, 2, 3, and 4.

Column 6: Multiply the unit cost multiplier on Schedule C, Column 4, by the detail on Schedule C, Column 4.

Column 7: Enter sum of lines 5 and 6 for each service area and transfer amounts in Column 7, lines 17 through 23, before and after, to Schedule D, Column 2; and Column 7, Lines 24 through 29, before and after, to Schedule E, Column 2; and Column 7, Lines 30 through 35 to Schedule F, Column 2.

SCHEDULE D - Apportionment of Patient Service Costs

This worksheet provides for the apportionment of home health patient service costs to Title XIX only. In addition, this worksheet provides for the application of the Title XVIII and Title XIX cost limitations, if applicable, to each home health agency's total allowable cost in determining the Medicaid reimbursable cost.

The computation of Medicaid reimbursable cost shall be determined by utilizing the lower of the average cost per visit, Title XVIII cost limits, or Title XIX cost limits compared on an aggregate basis.

Cost Per Visit Computation (for visits with service dates prior to 7/1)

Column 2 - Amounts - Enter in column 2 the amount for each discipline from Schedule C-1, column 7, lines as indicated in column 1.

Column 3 - Enter the total agency visits from statistical data Schedule A, column 1, for each type of discipline on lines 1 through 6.

Column 4 - This is the average cost per visit for each type of discipline. Divide the cost (column 2) by number of visits (column 3) for each discipline.

Column 5 - Enter Title XVIII limits from the Medicare notification letter for each discipline, lines 1 through 6.

Column 6 - Enter Title XIX limits as specified in the appropriate reimbursement letter for each discipline, lines 1 through 6, if applicable.

Column 8 - Enter Title XIX Program Visits (utilizing Medicaid Paid Claims Listings) for each discipline, lines 1 through 6.

Column 9 - Multiply the average cost per visit (column 4) by the Title XIX visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 9.

Column 10 - Multiply the Title XVIII Cost Limits (column 5) by the Title XIX visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 10.

Column 11 - Multiply the Title XIX cost limits (column 6) by the Title XIX visits (column 8) for each discipline, lines 1 through 6 and enter the product in column 11.

Line 7: Sum of lines 1 through 6 for appropriate column.

Line 8: Enter the lesser of column 9, column 10, or column 11.

Part II -- Cost Per Visit Computation (for visits with service dates on or after 7/1).

See instructions for Part I, columns 2 through 11.

Line 8: Enter the lesser of column 9, column 10, or column 11.

Line 9 -- Enter the total visits from Part I, line 7, Column 8 and Part II, line 7, Column 8.

PART III - Medical Supplies Computation

Column 1 - Enter cost from line 17, column 7, Schedule C-1.

Column 2 - Enter total charges from facility records.

Column 3 - Divide amount in column 1 by amount in column 2.

Column 4 - Enter Title XIX charges from Paid Claims Listings.

Column 5, Line 1 - Multiply ratio in column 3 by amount in column 4.

Column 5, Line 2 - Add amount in column 11, line 8, Part I, column 11, line 8, Part II, and column 5, line 1, Part III.

Schedule D-1, Calculation of Reimbursement Settlement

Part I, Computation of the Lesser of Reasonable Cost or Customary Charges

Line 1 -- Cost of services from Schedule D, Part III, line 2, column 5.

Line 2 -- Amount of charges from Medicaid paid claim listings.

Line 3 -- If line 1 is greater than line 2, enter the excess cost on line 3, if applicable.

Part II, Computation of Reimbursable Settlement

Line 4 -- Enter total reasonable cost from line 1.

Line 5 -- Enter excess reasonable cost from line 3, if applicable.

Line 6 -- Subtract line 5 from line 4.

Line 7 -- Enter amounts received from third party payors (from Title XIX paid claim listings).

Line 8 - Enter amounts received from the Medicaid Program (from Title XIX paid claim listings).

Line 9 -- Enter incentive payment (from Title XIX Paid Claim listings).

Line 10 -- Enter total interim payments (lines 7+8-9).

Line 11 -- Enter balance due Provider/Medicaid Program (line 6-10). Indicate overpayments in parentheses ( ).

Schedule E - Apportionment of Patient Service Costs (Waiver Program)

Part I, Before 07-01-

Column 2 - Enter amount in Column 2 from Schedule C-1, Column 7, lines 24 through 29.

Column 3 - Enter in Column 3, lines 1 through 6 total units/visits from Schedule A, Column 1, lines 7-12, for each discipline.

Column 4 - Compute the average cost per visit for each type of discipline. Divide the number of visits (Column 3) into the cost (Column 2) for each discipline of service on lines 1 through 6.

Column 5 - Enter the Medicaid Cost Limits per discipline or Average Cost. (The Department for Medicaid Services shall furnish the limits to the HHA effective July 1 of each year.)

Column 6 - Enter the Title XIX units/visits from the Medicaid Paid Claim Listings on lines 1 through 6.

Column 7 - Enter in Column 7 cost of services (Column 4 times Column 6 = Column 7) on lines 1 through 6.

Column 8 - Enter the product of Column 5 times Column 6 to determine Medicaid cost of services.

Part II, On or After 07-01-

Column 2 - Enter amount in Column 2 from Schedule C-1, Column 7, lines 24 through 29.

Column 3 - Enter in Column 3, lines 8 through 13 total units/visits from Schedule A, Column 1, lines 7-12 for each discipline.

Column 4 - Compute the average cost per visit for each type of discipline. Divide the number of visits (Column 3) into the cost (Column 2) for each discipline of service on lines 8 through 13.

Column 5 - Medicaid Cost Limits or Average Cost - Enter the Medicaid Cost Limits per discipline as indicated or average cost.

Column 6 - Enter the Title XIX units/visits from the Medicaid Paid Claim Listings on lines 8 through 13.

Column 7 - Enter in Column 7 cost of services (Column 4 times Column 6 = Column 7) on lines 8 through 13.

Column 8 - Title XIX Cost of Services - Enter the product of Column 5 times Column 6 to determine Medicaid cost of services per discipline on lines 8 through 13.

Part III - Calculation of Reimbursement Settlement

Line 15 - Enter cost of patient services (lesser of line 7, column 7, or line 7, column 8).

Line 16 - Enter cost of patient services (Lesser of line 14, column 7, or line 14, column 8).

Line 17 - Enter the total of allowable cost of patient services (Line 15 + Line 16, less amounts from Schedules E-1 and E-2).

Line 18 - Enter the total charges for the Waiver Program services from the Medicaid Paid Claim Listings.

Line 19 - Enter the lesser of line 17 or line 18.

Line 20a - Enter amount received from the Program for Waiver Program services from the Medicaid Paid Claim Listings.

Line 20b - Enter Continuing Income or TPL from the Medicaid Paid Claim Listings.

Line 21 - Enter Total Received (line 20a + 20b).

Line 22 - Enter Balance Due Program/Vendor (line 19-21). Indicate overpayments in parentheses ().

Schedule E-1 - Respite Care Cost Limitation

Column 1 - Enter in first column the name of each recipient.

Column 2 - Enter in Column 2 units of service per Medicaid recipient per fiscal year.

Column 3 - Enter in Column 3 Average Cost (from Schedule E, Part I, line 5, Column 4).

Column 4 - Enter in column 4 Total cost per Medicaid recipient per fiscal year (Column 2 X Column 3).

Column 5 - Enter in Column 5 excess of cost over $2,000 for each recipient for the fiscal year.

Schedule E-2, Adjustment to Home Adaptation Expense

Line 1 - Enter in line 1 the amount from Schedule E, line 6, Column 2.

Line 2 - Enter in line 2 the amount from Schedule B, line 29, Column 6.

Line 3 - Enter on line 3 Overhead Factor (line 1 divided by line 2).

Column 1 - Enter in Column 1 name of Medicaid recipient.

Column 2 - Enter in Column 2, Direct Cost for each recipient (from vendor records).

Column 3 - Enter in Column 3 Direct Cost X Overhead Factor (line 3).

Column 4 - Enter in Column 4 Cost in excess of the $500 limit per Medicaid recipient.

Line 4 - Enter on Line 4 the Total of the cost in excess of the KMAP limits (the sum of Column 4).

Home- and Community-Based Waiver (Extended Area)

Schedule F, Apportionment of Patient Service Costs (Extended Area)

Column 2 - Enter amounts from Schedule C-1, Column 7, lines 30 through 35.

Column 3 - Enter total units/visits from Schedule A, Column 1, lines 13-18 for each discipline.

Column 4 - Divide the number of visits (Column 3) into the cost (Column 2) for each discipline of service.

Column 5 - Enter the Title XIX units/visits from the Medicaid Paid Claim Listings.

Column 6 - Multiply Column 4 by Column 5 and enter results.

Line 7 - Enter the sum of lines 1 through 6.

Line 8 - Enter allowable cost of patient services (Line 7, Column 6).

Line 9 - Enter allowable cost of patient services (Line 8, less amounts from Schedules F-1 and F-2).

Line 10 - Enter the total charges for the Extended Area Program services from the Medicaid Paid Claim Listings.

Line 11 - Enter the lesser of line 9 or line 10.

Line 12a - Enter amount received from the Program for Extended Area Program services from the Medicaid Paid Claim Listings.

Line 12b - Enter Continuing Income or Third Party Liability (TPL) from the Medicaid Paid Claim Listings.

Line 13 - Enter Total Received (line 12a + 12b).

Line 14 - Enter Balance Due Program/Vendor (line 11-13). Indicate overpayments in parentheses ().

Schedule F-1 - Respite Care Cost Limitation

Column 1 - Enter in first column the name of each recipient.

Column 2 - Enter in Column 2 units of service per Medicaid recipient per fiscal year.

Column 3 - Enter in Column 3 Average Cost (from Schedule F, Part I, line 5, Column 4).

Column 4 - Enter in column 4 Total cost per Medicaid recipient per fiscal year (Column 2 X Column 3).

Column 5 - Enter in Column 5 excess of cost over $2,000 for each recipient for the fiscal year.

Schedule F-2, Adjustment to Home Adaptation Expense

Line 1 - Enter in line 1 the amount from Schedule F, line 6, Column 2.

Line 2 - Enter in line 2 the amount from Schedule B, line 35, Column 6.

Line 3 - Enter on line 3 Overhead Factor (line 1 divided by line 2).

Column 1 - Enter in Column 1 name of Medicaid recipient.

Column 2 - Enter in Column 2, Direct Cost for each recipient (from vendor records).

Column 3 - Enter in Column 3 Direct Cost X Overhead Factor (line 3).

Column 4 - Enter in Column 4 Cost in excess of the $500 limit per Medicaid recipient.

Line 4 - Enter on Line 4 the Total of the cost in excess of the KMAP limits (the sum of Column 4).

(L) SCHEDULE G - HOME HEALTH AGENCY DATA

A. STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS:

Section A is provided to show whether the amount of costs to be reimbursed by the Medicaid Program includes costs resulting from services, facilities, and supplies furnished to the vendor by organizations related to the vendor by common ownership or control.

Section A shall be completed by all vendors.

B. Section B is provided to show the total compensation paid for the period for sole proprietors, partners, and corporation officers, as owner(s) of the Home Health Agency. Compensation is defined as the total benefit received (or receivable) by the owner for the services he renders to the institution. It includes salary amount paid for managerial, administrative, professional and other services; amounts paid by the agency for the personal benefit of the owner; and the cost of the assets and services which the owner receives from the agency and deferred compensation.

C. Section C is provided to show total compensation paid to each employed person(s) to perform duties as administrators or assistant administrators. List each administrator or assistant administrator who has been employed during the fiscal period. List the name, title, percent of customary work week devoted to business, percent of the fiscal period employed, and total compensation for the period.

D. Section D - Certification by Officer or Director of the Agency. This form shall be read and signed by an officer or director of the HHA. Sections 1877(a)(1) of the Social Security Act state that, "Whoever knowingly and willfully makes or causes to be made any false statement or representation of material fact in any application for any benefit or payment under this title--shall (i) in the case of such a statement, representation, concealment, failure or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and

upon conviction thereof fined not more than $25,000 or imprisoned for not more than 5 years, or both, or (ii) in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than 1 year or both."

upon conviction thereof fined not more than $25,000 or imprisoned for not more than 5 years, or both, or (ii) in the case of such statement, representation, concealment, failure or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than 1 year or both."